HMICS Improving Policing Across Scotland

Healthcare Improvement Scotland

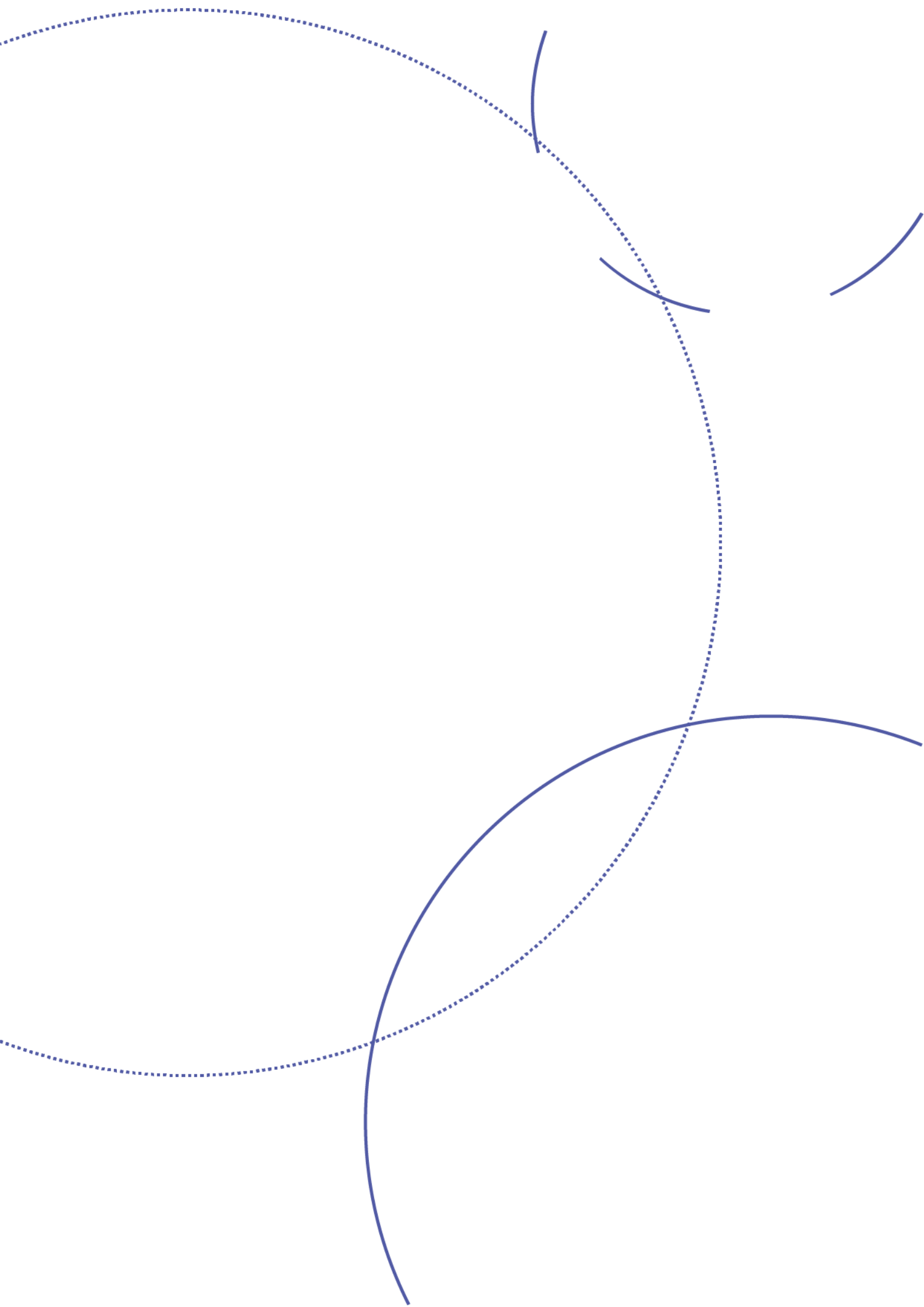
Custody inspection report

Forth Valley

July 2025

EFQM

npm national preventive mechanism



HM Inspectorate of Constabulary in Scotland

HM Inspectorate of Constabulary in Scotland (HMICS) is established under the Police and Fire Reform (Scotland) Act 2012 and has wide ranging powers to look into the 'state, effectiveness and efficiency' of both the Police Service of Scotland (Police Scotland) and the Scottish Police Authority (SPA). HMICS has a statutory duty to inquire into the arrangements made by the Chief Constable and the SPA to meet their obligations in terms of best value and continuous improvement. If necessary, it can be directed by Scottish Ministers to inspect anything relating to the SPA or Police Scotland as they consider appropriate.

Healthcare Improvement Scotland (HIS) is the national improvement agency for health and social care. It is responsible for supporting healthcare providers to deliver high quality care and scrutinising those services to provide public assurance about the quality and safety of that care.

Places of detention, including police custody centres within the UK, are monitored as part of the human rights treaty: 'Optional Protocol to the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (OPCAT)'. OPCAT requires that all places of detention are visited regularly by a National Preventive Mechanism (NPM), an independent body or group of bodies which monitor detainee treatment and conditions. HMICS is one of several bodies making up the NPM in the UK.

Joint HMICS/HIS custody inspections focus on the delivery of custody services by Police Scotland and associated healthcare provision by NHS boards and Health and Social Care Partnerships across Scotland. These are underpinned by the joint HIS and HMICS Framework to inspect that ensures a consistent, objective and human rights-based approach to the collaborative work.

This inspection was undertaken by HMICS in terms of Section 74(2)(a) of the Police and Fire Reform (Scotland) Act 2012 and is laid before the Scottish Parliament in terms of Section 79(3) of the Act.

Contents

Our inspection

During the course of 2022, HM Inspectorate of Constabulary in Scotland (HMICS) and Healthcare Improvement Scotland (HIS) collaborated on a baseline review of the provision of healthcare services to police custody centres across Scotland. A report outlining our findings and recommendations was published in January 2023. We used learning from the review to develop a framework to inspect healthcare services within police custody, and to devise a methodology for the joint inspection of police custody centres.

Following our completion of the baseline review we commenced a programme of joint custody inspections and, to date, have published seven custody inspection reports. The findings from these can be found on our website. We have also recently published a revised version of our custody inspection framework, which can be found here. It outlines the quality indicators that form the basis of our custody inspections. This report relates to our inspection of the only primary custody centre in the Forth Valley division area, which is at Falkirk Police Station.

The inspection was carried out by HMICS and HIS, the aim of which was to assess the treatment of, and conditions for, individuals detained at the custody centres. This report provides an analysis of the quality of custody centre operations as well as the provision of healthcare services in the custody centre.

The onsite stage of the inspection took place in February 2025. As part of our inspection, we reviewed the Police Scotland National Custody System (NCS) and examined a representative sample of detainees processed at the custody centres during November 2024. We assessed the physical environment, including the quality of cells, and observed key processes and procedures relevant to police custody operations. We also spoke with people detained at the custody centre and interviewed custody staff and healthcare professionals during our visit.

While we have made no new recommendations regarding custody centre operations for Police Scotland in this report, we have outlined our concerns regarding several issues, which despite previous recommendations, were also evident during this inspection. This elevates our concern regarding a lack of pace in addressing previous recommendations with national relevance.

As such, we found a lack of consistency in the recording of information on the NCS. While some aspects of custody centre operations were recorded well, such as the recording of information relating to criminal justice decisions, we saw consistent recording errors regarding movements, meals, provision of legal rights, handovers, healthcare consultations, care plan rationale and grounds to delay release. We have continued to find disparities, in some cases, between the risk assessments undertaken and the corresponding care plans put in place to mitigate risk.

In addition, we found limited evidence of quality assurance checking of operational practice taking place, which has been a recurring theme in our previous reports. We have also highlighted the need for increased line management presence within custody centres to monitor and influence the quality and consistency of custody centre operations.

We have outlined the recommendations made in previous reports in respect of these issues and would stress that they have equal relevance for the custody centre at Falkirk.

We found the provision of healthcare within the custody centre to be generally good, and that it was being delivered by way of an established and well-managed model. We have however, made recommendations for improvement in respect of prescribing processes, training for staff on the use of compliance aids, and adherence to MAT standards.[1]

We wish to thank the officers and staff of the Criminal Justice Services Division of Police Scotland, as well as staff from NHS Lothian, which is responsible for the overall management of healthcare at Falkirk custody centre.

The custody inspection programme is overseen by Ray Jones, Lead Inspector at HIMCS, with support from HMICS Associate Inspectors and HIS Inspectors.

Craig Naylor
His Majesty's Chief Inspector of Constabulary
July 2025

[1] The Scottish Government's Medication Assisted Treatment (MAT) standards came into force in April 2022. These are evidence-based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland.

Key findings

- Falkirk custody centre is the only custody centre in the Forth Valley divisional area, serving the sheriffdoms of Falkirk, Stirling and Alloa. It is comprised of 29 cells.

- The centre is in good condition and generally well maintained albeit subject of a pending renovation to rectify longstanding issues with custody infrastructure.

- The steel sliding rear yard access gates were functioning at time of inspection, however staff indicated they were normally found to be open and insecure as a result of repeated malfunction.

- Interviews with staff indicated cleaning standards were subject of frequent criticism, which ranged from poor levels of tidiness to inappropriate cleaning practices. There was no evidence this poor practice had been escalated via the available service review protocols for remedial action.

- The sizeable holding room contained useful information posters directed towards detainees regarding expected conduct. Additional posters were also displayed that provided information on available support for families and dependents of detainees or those destined for prison. We consider this to be good practice.

- The centre featured three charge bars. Two adjacent to the custody office were bright, easily accessible and separated by a full floor-to-ceiling enclosure affording increased discretion. A third, described as the ‘discrete charge bar’, could be accessed from the secure car park, providing appropriate discretion for vulnerable detainees.

- Detainee property storage consisted of floor-mounted lockers located in the central custody corridor immediately to the rear of the charge bars. Each individual locker had keys left within the unlocked doors, and were therefore not secure.

- There were limited shower options as a result of outstanding repairs and lack of separation or modesty screens between showers.

- Custody staff highlighted a lack of management visibility, indicating that some managers work from home, and compressed hours patterns are common, which reduce the number of days at work, and visibility to staff.

- We observed six detainees being booked in. Detainees were processed promptly, and the manner and professional engagement by officers and staff was consistently of a high standard, evidently placing detainees at ease.

- We examined 40 records from a sample of 383 from the NCS, created during the sample period of November 2024, with 305 related to males and 78 related to females.

- Within the sample, we found that the average time in detention was 16 hours, lower than the 21 hours that we found in our inspection of Glasgow custody centres. The average time of waiting to be booked in was 14 minutes, which was significantly lower than found at Glasgow centres.

- Three children and one older child on compulsory supervision were included in our sample. None were placed in a cell but were observed and supervised in an interview room. All had a parent or social worker present. We consider this to be good practice.

- Following a vulnerability risk assessment, 29 detainees were assessed as high risk and 11 as low risk. Of those marked as high risk, 15 were placed on level 1 observations without any other apparent risk mitigation in place.

- The dispensing of medication was recorded consistently on the NCS although only one staff member was assigned to each entry. Accordingly, it is not possible to ascertain if two members of staff carried out medication dispensing in accordance with policy.

- We interviewed 11 detainees during our inspection. All were complimentary about the staff and the care provided. Two offered particular praise for the additional time staff had spent to speak to them and provide support.

- Falkirk custody centre sits within the NHS Forth Valley board area. Healthcare is delivered by the Southeast Scotland Police Custody Healthcare and Forensic Examination Service, which is hosted and managed by NHS Lothian.

- We found healthcare to be well managed, with NHS Lothian's Royal Edinburgh Hospital and Associated Services (REAS) providing monitoring and oversight through their clinical and care governance structures.

- We noted that the current process for prescribing controlled drugs did not include a wet signature of the prescriber. This is a concern, and we have sought written assurance from NHS Lothian that prescribing protocols for controlled drugs are safe and compliant with the relevant regulations.

- Healthcare staff dispensed medication into multi-compartment 'compliance aids' to enable custody staff, who received email instructions from healthcare staff, to support safe medicine administration. However, the service did not have a current SOP or training package to support their use.

- Processes were in place for confirming, collecting and administering community prescriptions for patients within custody who lived locally and were prescribed Opioid Substitution Therapy (OST). There was no stock of OST medicines within the centre, meaning detainees had their treatment stopped, requiring them to recommence their OST once liberated, which did not align with MAT standards.

- Although there was a process in place for nicotine replacement therapy for detainees who smoked, feedback obtained from detainees indicated that this was not consistently offered.

- Naloxone was available within the centre which was administered by nursing staff and trained police officers. However, 'take home naloxone' was only made available for patients who had been identified as having a history of substance use, despite the NHS Lothian protocol stating that it should be offered to all detainees.

- At the time of our inspection, Blood Borne Virus (BBV) testing was not available at the custody centre. We were told that a pilot was being undertaken in another custody centre covered by REAS.

- There was evidence of signposting detainees to community support services and custody staff were knowledgeable about the support available in the community. A range of leaflets were available for mental health, substance use, health and wellbeing, harm reduction, peer support and family support available in the community.

Recommendations

Recommendation 1

NHS Lothian must review the prescribing processes in Falkirk police custody centre and strengthen the governance of medication prescribing.

Recommendation 2

NHS Lothian should ensure all staff receive appropriate training and guidance to support the use of compliance aids.

Recommendation 3

NHS Lothian and REAS should continue to review their pathways for people who use the Substance Use Service to ensure it aligns to the principles of the MAT standards.

Recommendation 4

NHS Lothian should ensure that all detainees at risk of nicotine withdrawal are offered nicotine replacement therapy.

Recommendation 5

NHS Lothian should ensure that take home naloxone is offered to all detainees in accordance with the induction policy.

Recommendation 6

NHS Lothian should urgently review the options for the delivery of BBV testing so that it is available in Falkirk custody centre.

Areas for improvement

Areas for improvement	Number
Falkirk custody centre should ensure all operational and storage areas are clear and uncluttered, and that general cleaning standards are improved through adherence to relevant cleaning guidelines.	1
Falkirk custody centre should ensure that handovers are undertaken and recorded in line with existing guidance and standards.	2

Previous recommendations

The following provides an outline of recommendations that we have made in previous custody inspection reports, which continue to have equally significant relevance for Falkirk custody centre. These have been highlighted within this report where relevant.

Custody inspection report (Recommendation number)	Recommendation date	Paragraph reference
Argyll and West Dunbartonshire (1)	24 October 2024	20, 32, 45
Fife (3)	28 March 2024	28
Dumfries and Galloway (5)	08 November 2023	48
Greater Glasgow (1)	06 March 2025	57
Greater Glasgow (2)	06 March 2025	59
Greater Glasgow (3)	06 March 2025	72
Ayrshire (1)	30 May 2024	77
Ayrshire (2)	30 May 2024	88
Northeast Scotland (1)	14 December 2021	94
Lanarkshire (3)	20 April 2023	94
Tayside (3)	20 July 2023	97
Argyll and West Dunbartonshire (3)	24 October 2024	104
Dumfries and Galloway (13)	08 November 2023	109

Context

1. Custody is delivered throughout Scotland by the Police Scotland Criminal Justice Services Division (CJSD). This division is one of several national divisions which sit alongside and support the thirteen local policing divisions. CJSD is led by a Chief Superintendent who reports to an Assistant Chief Constable and, in turn, to a Deputy Chief Constable. Custody is delivered in accordance with the custody standard operating procedure, which is updated and amended regularly to reflect changes in practice guidelines and expectations.

2. National custody throughput fell to a relatively low level due to the Covid-19 pandemic, however there has been a steady increase in recent years as indicated in the table below. Falkirk custody centre has also seen an increase in throughput over the past two fiscal years. The national trend reflects a 4% increase in throughput volume from 2022-23 to 2023-24, whereas there was a 16% increase in throughput over the same period at Falkirk. There is no clear causal factor for this.

Table 1 - National custody throughput[2]

Year	2019-20	2020-21	2021-22	2022-23	2023-24
Throughput	90311	87408	84010	96279	99986

Table 2 - Custody centre cell capacity and throughput

Custody centre	**Number of cells**	**2022-23**	**2023-24**
Falkirk	29	4370*	5057*

*It is important to note that the number of arrested persons includes individuals who have appeared in custody on more than one occasion within the reporting period. This excludes voluntary attendance, S.23 MDA 1971 detentions, those in transit and rejected arrests. This is in line with SPA published figures each quarter.

[2] Annual throughput data differs from that previously reported. This is because Police Scotland have adopted new audit software and data recording rules.

3. Custody centres in Scotland are organised into clusters, each led by a Cluster Inspector. The Forth Valley division, encompassing the local authority areas of Falkirk, Stirling and Clackmannanshire has one custody centre, based at Falkirk Police Station. Falkirk police custody centre serves the sheriffdoms of Falkirk, Stirling and Alloa. There are no ancillary custody centres. Very few detainees are brought to Falkirk from other areas and almost all those arrested in Forth Valley division are processed at Falkirk. The occasional exceptions are those arrested in the far west of the divisional area, who are sometimes taken to Clydebank custody centre.

4. At the time of our inspection, all staff observed the CJSD 222b[3] shift pattern. Each staff team at Falkirk custody centre was made up of two police sergeants, a criminal justice police custody and security officer (CJPCSO) team leader, two custody constables and four CJPCSO staff.

Independent custody visitors

5. Under the Police and Fire Reform (Scotland) Act 2012, the Scottish Police Authority (SPA) is required to make arrangements for independent custody visitors to monitor the welfare of people detained in police custody. Regular visits to custody centres are carried out by volunteer independent custody visitors from the local community. Independent Custody Visiting Scotland (ICVS) manages the process and coordinates volunteers. Any concerns identified by custody visitors are raised with custody staff during their visits and outcomes are recorded in custody records. ICVS is also a member of the UK's NPM.

6. During our inspection, we reviewed the ICVS service book that is completed following each visit by the custody visitors. This reflected a pattern of recent and regular visits with no significant issues raised.

[3] The CJSD 222b pattern relates to custody staff working two early shifts, two late shifts and two nights, followed by four non-working days.

Methodology

7. HMICS and HIS undertook a wide range of activities during the baseline review of healthcare provision in custody to inform the development of our custody inspection methodology. These activities are outlined in the aforementioned report published in January 2023. As a result, the following key stages have been undertaken for this inspection and will form the basis of future joint inspections.

8. HIS requested key pieces of evidence in advance of the onsite inspection relevant to healthcare provision. On the first day of the inspection, HIS inspectors issued a letter to the HSCP to request a follow-up meeting with NHS managers to allow the inspection team to discuss key issues arising from the onsite inspection and the review of evidence.

9. During the inspection, we examined the treatment of, and conditions for, detainees at the centres. We observed key custody processes and assessed the custody environment, condition of cells and facilities for detainees. We undertook interviews with custody staff and managers, as well as healthcare practitioners (HCP) that were present during our visit. We also spoke with people detained in custody at the time.

10. A proportional sample of custody records were examined from those recorded at Falkirk custody centre during November 2024. Of the 383 records created during that period, 305 related to males and 78 related to females. We sampled 40 records for review on NCS, which equated to just over 10% of throughput in that month.

11. The sample was selected to be broadly representative of the proportions of men, women and children held in custody during the aforementioned period. Based upon this, sampling was weighted to ensure that women and children were included during random selection.

12. The review of NCS records provided valuable information on aspects of risk assessment, observation levels, and compliance with the expectations of the Police Scotland care and welfare of detainees, standard operating procedure.

Outcomes

Custody centre condition and facilities

13. Falkirk custody centre is of late 20th century construction and forms part of Falkirk Police Station. It has been functioning as a custody centre firstly with Central Scotland police and thereafter since the establishment of Police Scotland. Twenty six of the 29 operational cells were inspected during this visit. The centre is in generally good physical condition albeit is subject of an anticipated programme of renovation to rectify longstanding issues with custody infrastructure.

14. The custody centre is located on a single level attached to the main police station and is accessed via the rear parking yard, which serves both the custody centre and wider police station for personal and operational police vehicles. This large car park enclosure, which was accessed directly from the adjacent public road, was bounded by high steel fences which have additional rotating barbed security features designed to prevent unauthorised ingress or egress from the compound. There were also two steel sliding electronically powered security gates at either end of the compound as part of a one-way traffic flow system.

15. It was noted that while these steel sliding gates were functioning at time of inspection, staff and officers indicated these external gates were normally found to be open and insecure as a consequence of frequent and repeated malfunction of the motor used to power the mechanism.

16. This malfunction had been addressed on multiple occasions without success, with supervisory staff intimating the latest inspection of the fault had determined that the electronic motors were inappropriate for the size of the gates and plans were being developed to replace these components with more capable hydraulic mechanisms. No date has been set for this remedial work to commence.

17. The car park led to a large, caged vehicle dock secured by fully functioning double, swinging electronic gates, controlled and monitored remotely via CCTV linked to the custody office. The yard and cage were free of unnecessary or hazardous items however, it was notably untidy with numerous items of litter and general debris which had evidently been present for some time.

18. The vehicle dock, car park and custody centre were covered by numerous CCTV cameras linked to the custody centre office. Crucially, 12 cameras located between the custody dock and the charge bar were inoperative at the time of inspection, resulting in blind spots throughout this entire route into the custody centre. This unmonitored area consists of a sizeable corridor containing the holding room and, via a further insecure door, an exit corridor to a secured external door. The unmonitored access corridor did, however, have fully functioning affray bars on two walls.

19. A further ongoing safety issue brought to our attention by staff, related to a slippery surface developing on the main custody corridor floor whereby any spillage of water or moisture rendered the area hazardous for both staff and detainees. The issue had been appropriately logged by managers and prioritised for rectification during anticipated renovations of multiple areas within the centre, however, no dates have been confirmed for the work to commence.

20. As outlined in our report on the joint inspection of primary custody centres in Argyll and West Dunbartonshire, we have made recommendations and identified areas for improvement which have relevance across the custody estate. **Recommendation 1**, of that report states that:

    "Police Scotland should ensure that the maintenance and repair of crucial custody infrastructure is addressed swiftly to maintain operational capability as well as safety and security standards."

    Additionally, an area for improvement raised in the same report stated:

    "The custody centres should review internal and external security features and take appropriate steps to mitigate risks."

    While these issues have relevance for Falkirk custody centre, we do not intend to make additional recommendations in this regard.

21. Falkirk featured a large separate detainee holding area which was accessed via the ground level entrance access corridor leading from the vehicle dock. The spacious and well-lit, ten by four metre holding room, had a single point of entry and was separated by low concrete dividers into four spaces containing low benches. Although the CCTV and microphones were inoperative at the time, the room contained two functioning affray bars.

22. The space contained a variety of information posters. Some were directed towards detainees regarding expected standards of conduct as well as posters providing various information relating to domestic abuse recognition. There was information on available support services such as a family support service contact for families and dependents of detainees or those destined for prison. There were also police only information posters conveying details regarding expected standards of police conduct. We considered this comprehensive and well-placed provision of information to be good practice.

23. Falkirk custody centre operated three charge bars. Two main charge bars, located adjacent to the custody office, were bright, easily accessible and separated by a full floor-to-ceiling enclosure affording improved confidentiality. Access to the staff side from the custody corridor was only secured by low saloon style swing doors which were permanently held open offering relatively unhindered access to staff areas, including the insecure custody office. Local custody staff were made aware of this issue.

24. A third facility described as the discrete charge bar, was located off the cell corridor and designated as the female corridor. This bright and spacious room could be accessed from the secure car park enabling further separation, which we consider to be a useful and practical means of affording enhanced levels of discretion to vulnerable detainees.

25. Detainee property storage was located immediately to the rear of the charge bars in a corridor space which was open to any and all persons using the custody corridor. This storage consisted of sets of lockable floor mounted lockers which were utilised for storing detainee property within individually tagged bags, routinely handled under comprehensive CCTV including overhead coverage in the charge bar. Each individual locker had keys, however these were routinely left within the unlocked doors and though they were covered by CCTV cameras, these images were not actively monitored.

26. The staff office was a reasonable size for the four available workspaces. There were wall mounted CCTV screens displaying clear images of external security points and custody cells. These were well-placed, adjustable and capable of being seen from all workspaces. The office was well-lit and air conditioned and connected to the staff side of the charge bar via a swing door with a two-way mirrored glass insert to provide a view from the interior only. This door, however, was not secured from unauthorised entry.

27. The staff office also accommodated the in-cell, CCTV viewing room, which was a small anteroom located off the main office. The quality of the images on the two-screen facility were bright, sharp and fully controllable providing unobstructed views of cell occupants. The viewing room was well-lit and ventilated though very cramped and was not separated from the main office by any closure, meaning users were exposed to general custody related movement and activity. Furthermore, the space was evidently utilised as a storage space for a variety of custody related materials and personal belongings, which coupled with the open access, increased the likelihood of distracting incursions which could negatively impact user comfort and attentiveness.

28. As outlined in our report on the joint inspection of primary custody centres in Fife, we have made recommendations which have relevance across the custody estate. **Recommendation 3**, of that report states that:

    "Police Scotland should make improvements to the location of the CCTV viewing facilities at the centres to reduce the likelihood of distraction."

    While this has relevance for Falkirk custody centre, we do not intend to make an additional recommendation in this regard.

29. The charge bar area afforded convenient access to the custody staff office and wider custody centre via connecting corridors. These areas housed additional facilities such as detainee engagement and interview rooms, well-appointed medical examination rooms, staff-only rest areas, multiple storerooms, photograph and impressions rooms, and forensic storage.

30. The centre had a well-appointed shared detainee and staff kitchen, which was accessed from a connecting corridor adjacent to the interview centre and had a food preparation area which contained a variety of appropriate foodstuffs. The kitchen was reasonably clean and hygienic. There was adequate lighting, hygiene products, fire safety equipment, first aid and suitable food hygiene and preparation guidance. The kitchen also gave access to an adjoining staff rest room.

31. There were two separate shower facilities within the centre. One triple shower, located in the main male cell corridor had no means of separation or modesty between the showers therefore only one shower was used at a time. A second, single shower located in a separate cell corridor was equipped with a screen door. However, this facility had, according to staff, been inoperative for some considerable time and, at the time of inspection, was being used as a mattress store thereby denying detainees access to the only shower facility affording reasonable levels of discretion and modesty.

32. As outlined in our report on the joint inspection of primary custody centres in Argyll and West Dunbartonshire, we have made recommendations which have relevance across the custody estate. **Recommendation 1**, of that report states that:

    "Police Scotland should ensure that the maintenance and repair of crucial custody infrastructure is addressed swiftly to maintain operational capability as well as safety and security standards."

    While this has relevance for Falkirk custody centre, we do not intend to make an additional recommendation in this regard.

33. There were sufficient, clearly visible and practically located fire safety signage, emergency lighting, and materials located throughout the custody centre. This included fire safety warden specific guidance in a clearly marked location. There were stores of rigid handcuffs for the evacuation of detainees in the charge bar area of the facility, however, these items were not numbered.

34. While routine weekly fire alarm tests were being carried out, no recent physical evacuation fire drills had taken place at the centre.

35. There were three bespoke detainee interview rooms located in a separate secure corridor accessed from the main custody centre. The rooms were artificially lit and well-ventilated with secured desks but unsecured seats. The rooms were not covered by the custody CCTV or affray bar links, however, there were affray bars in the interview room corridor. A fourth interview room was being utilised as a store.

36. With the notable exception of the non-functioning cameras within the entrance corridor, the centre was adequately provisioned with well situated and fully functional CCTV cameras linked to the charge bar and staff offices. Staff were not issued with personal alarms, however, the majority of wall surfaces and adjacent rooms were fitted with multiple affray panels, the activation of which will activate a loud siren and blue flashing light audible throughout the centre. These panels were easily accessible, highly visible, and linked to a central control panel located in the custody office. Affray panels were subject of a regular testing regime.

37. General levels of untidiness were observed throughout the centre in various operational areas such as the vehicle dock, livescan/intoximeter room, storage spaces and kitchen. Interviews with staff indicated cleaning standards are subject of regular comment, which anecdotally range from poor levels of tidiness to inappropriate cleaning practices such as using a single mop to clean multiple areas and surfaces. There was no evidence this poor practice had been escalated via the available service review protocols for remedial action.

Area for improvement 1

Falkirk custody centre should ensure all operational and storage areas are clear and uncluttered, and that general cleaning standards are improved through adherence to relevant cleaning guidelines.

38. The general condition of the custody centre, notwithstanding the aforementioned issues concerning defective cameras, gates, showers and flooring, was good. That said, the nature of what appear to be longstanding deficiencies, bear such significance to the effective and safe operation of the facility that their swift rectification should be prioritised.

Condition of cells

39. The cells inspected were found to be in good physical condition with no notable defects or ligature hazards. Two cell closures related to a broken call button and a faulty toilet. All faults were previously noted for remedial action.

40. The cells were distributed as 24 male and five female in what amounted to four cell corridors. There were two dedicated dry cells, two cells had been repurposed as stores and a further cell was utilised solely as a dedicated solicitor phone consultation room. Five cells designated as female cells, were located in a separate corridor from the remainder of the facility. The separated corridors enabled gender or age-based segregation, which staff indicated was occasionally employed for both age and gender segregation where appropriate. This is considered good practice.

41. All cells contained toilets with external controlled flush and paper supplied on demand. Detainees had access to numerous, well-distributed washbasins supplied with hot and cold water, which supplemented the wall recessed anti-ligature handwashing units within each cell, which provided running hot and cold water on demand. The single functioning shower facility, which contained three un-segregated showers, was wheelchair accessible and there were ample washing materials and feminine hygiene products available at the facility.

42. While cells were wheelchair accessible, none of them were further adapted for accessibility needs. They each contained low sleeping plinths capable of accommodating the ample supply of mattresses and pillows. All cells were well lit by dual mode artificial lighting natural light from variously positioned skylights or glass brick windows. The cells had call buttons but no intercom, and these were linked to the charge bar and staff office. Those available for inspection were tested and were fully operational.

43. All cell doors were of a more dated construction with two-position service hatches only and fitted with slam locks. Staff stated these doors were scheduled to be upgraded to more contemporary three position hatches.

44. All cells contained smoke detectors linked to the charge bar and office and contained well placed functional CCTV units albeit the microphones were not operational in either the cells nor external cell corridors at time of inspection. This significant deficiency, along with the cell door upgrades, were subject of the aforementioned planned renovations.

45. As outlined in our report on the joint inspection of primary custody centres in Argyll and West Dunbartonshire, we have made recommendations have relevance across the custody estate. **Recommendation 1**, of that report states that:

"Police Scotland should ensure that the maintenance and repair of crucial custody infrastructure is addressed swiftly to maintain operational capability as well as safety and security standards."

While this has relevance for Falkirk custody centre, we do not intend to make an additional recommendation in this regard.

46. Cell checks were being conducted each week by custody staff. These included a check of the Automated External Defibrillator (AED) equipment. Issues requiring attention are recorded electronically as well as manually on the office 'white board' and addressed under the direction of the custody supervisor. All inspected cells were generally clean, tidy and subject of a regularly scheduled cleaning regime.

47. Cleaning is provided by police appointed cleaners who attend seven days per week. If, however, cells are vacated in the absence of appointed cleaners and capacity is required, custody staff stated that they will undertake the cleaning duties, despite not having received any formal training in the appropriate use of cleaning chemicals.

48. As outlined in our report on the joint inspection of primary custody centres in Dumfries and Galloway, we have made recommendations that have relevance across the custody estate. **Recommendation 5** from that report states that:

"Police Scotland should ensure that custody staff receive appropriate training and guidance where cleaning is part of their role."

While this has relevance for Falkirk custody centre, we do not intend to make an additional recommendation in this regard.

Custody centre staffing

49. Custody sergeants are responsible for all criminal justice decisions and their function is specified in legislation. CJPCSO Team Leaders (team leaders), line manage custody staff and are responsible for the care and welfare of detainees, but only once a sergeant has approved the initial care plan.

50. Falkirk was one of the first custody centres in Scotland to operate with team leaders as part of the criminal justice hub operating model. Each team has two sergeants and one team leader however, when both sergeants are available for duty, one is often moved to supervise another centre as a peripatetic resource. Team leaders are not relocated to other centres. When they are absent, they are not replaced, and their responsibilities are adopted by sergeants.

51. In addition to sergeants and team leaders, each team has two constables and four CJPCSOs except for one team, which has three CJPCSOs. We were informed that an existing staffing challenge at the centre relates to the number of staff who were not sick but have workplace restrictions, limiting what tasks they can do. We were advised that management activity was underway to address this, however it can at times, have a detrimental impact on custody centre operations.

52. We noted that Falkirk, with two per team, has twice the cohort of constables than we have found at any other centre during the course of our inspections. Other centres have either one constable per team or, as we found in Glasgow custody centres, no constables. Constables are required when there is a desire to run a centre without a sergeant, as “constable led”.

53. CJSD employ a methodology known as Operational Base Levels (OBL), which refers to a framework for managing minimum staffing across the custody estate. Nationally, the custody OBL is broadly designated as one sergeant plus one staff member, a CJPCSO, team leader or constable for every ten detainees. Because Falkirk has 29 operational cells, their OBL is a sergeant plus three staff. We were informed that if there was only a sergeant and two staff members, detainee numbers could be capped at twenty.

54. There was a universal feeling among staff interviewed that the ratio of one staff member to ten detainees, as a basis for the OBL, was not sufficient. None of the staff were aware of any formal analysis having been carried out to inform the current OBL ratio policy.

55. Custody staff raised concerns that team leaders are counted as CJPCSOs but generally they supervise rather than contribute to core tasks, which can cause frustration. Staff indicated that typically Falkirk has a sergeant and team leader, who remain in the office as supervisors, leaving two CJPCSOs to carry out the majority of tasks. When staffing falls short, centres are required to make a dynamic risk assessment, but this was viewed by staff as an expectation that they would absorb the additional pressure as closing the centre or capping detainee numbers is resisted.

56. Some staff stated that morale was "not great" and described the mood as being "pretty deflated", which was attributed in part to the frequent diversion of Falkirk based resources to other custody centres. They stated this can occur where conscientious staff with high attendance levels are often diverted to supplement those centres that have greater gaps in staffing.

57. Several custody staff spoke about feeling pressurised at busy times with insufficient staff numbers, a sentiment common at other centres, and particularly as highlighted in our Greater Glasgow report. **Recommendation 1** of that report stated:

"Police Scotland should examine the staffing levels at the custody centres in Glasgow and make arrangements to ensure that appropriate staff resource is in place to maintain safe and effective custody centre operations."

Consideration should therefore be given to reviewing the rationale for the existing OBL to ensure it remains suitable and fit for purpose.

58. Falkirk is the CJSD divisional HQ and is where senior management meetings are held. However, custody staff referred to a lack of management visibility, some noting that they rarely saw senior managers and did not see the custody inspector often.

59. It is our view that motivation, inspiration, compliance, efficiency and effectiveness are delivered through visible and present leadership. We were advised that several inspectors and senior officers work compressed hours patterns, which reduces their number of working days, and visibility to staff. Combined with an element of home working, there is an apparent lack of visible leadership at the custody centre. This is similar to the findings outlined in our report on the joint inspection of custody centres in Greater Glasgow, where **Recommendation 2** stated:

"Police Scotland should ensure that an appropriate level of management presence is maintained at custody centres in order to improve the quality and consistency of operational practice and to ensure compliance with approved protocols and standards."

While this has relevance for Falkirk custody centre, we do not intend to make an additional recommendation in this regard.

Arrival at custody and booking-in process

60. When a detainee is arrested, the arresting officers contact the custody centre to provide brief information on the detainee and relevant circumstances. This allowed custody staff to commence background checks on various police IT systems, notably CHS, PNC, the national custody system and iVPD,[4] to better understand detainee particulars prior to their arrival.

61. We observed six detainees being booked in. Detainees were brought from vehicles into a holding room but were processed promptly. On each occasion, an arresting officers spoke with the sergeant to discuss the authorisation of arrest. We noted this was carried out swiftly, as the sergeant had already checked the incident and where applicable, the crime report, to assess the circumstances prior to arrival.

62. We saw two charge bars being used simultaneously to speed the booking in process for detainees and there appeared to be no issues with noise or maintaining the integrity of personal information.

[4] Police information systems include the Police National Computer system (PNC), Criminal History System (CHS), and interim Vulnerable Persons Database (iVPD).

63. In our examination of the NCS, we found that the average time of waiting in the sample was 14 minutes, which was significantly lower than found on our recent inspection of Glasgow custody centres. The longest delay in being booked in to custody was 43 minutes, however this record related to a detainee that was booked in at Dundee custody centre who was moved over a weekend to Falkirk to create capacity at Dundee. Of the remaining records, only three indicated a delay exceeding thirty minutes and in each of these it was for only a few minutes longer than thirty minutes. Overall, this reflected a very efficient booking-in process at the centre.

64. The manner and professional engagement of officers and staff was of a consistently high standard, evidently placing detainees at ease. We saw empathy, respect and consideration being displayed. Staff appeared kind and thoughtful and spoke with detainees about the availability of healthcare and third sector support agencies. We consider this to be very positive practice.

65. Strip searches were conducted in the destination cell and staff ensured that the CCTV images did not appear on a monitor at the time of search. Of the detainees who we observed being booked in, the strip searches were carried out with custody staff present and on one occasion was carried out by two custody sergeants.

66. We noted that CJPCSOs at the centre did not wear stab vests at the time of our visit. However, we are aware of national policy changes since the time of our inspection that has mandated the wearing of stab vests. Some standard searches were conducted by police officers and some by custody staff with no clear policy approach to this. The metal detecting wand was used on one occasion out of six detainees searched.

Legal rights

67. Falkirk custody centre consistently has a sergeant on duty. Part of a sergeant's role is to record the necessity and proportionality of arrest under the Criminal Justice (Scotland) Act 2016, giving due consideration to the Lord Advocates Guidelines (LAG) and apply a rationale for that and any subsequent criminal justice decision making. The final decision for the sergeant, is to consider the disposal for each detainee and accompany that with a detailed rationale recorded on the NCS. Of the detainees we observed and those we examined on the NCS, we found that the authorisation of arrest in each case was appropriate, and each was recorded correctly on the NCS.

68. We saw that the team leader or sergeant visited each person being booked in to get a sense of their presentation and evaluate the risk, which we consider to be good practice. There was an evident desire to turn detainees around swiftly if they were to be released, avoiding the use of a cell altogether when possible.

69. All detainees were provided with information on their rights to a solicitor and reasonably named person, and staff ensured that these were fully explained. We noted that a letter of rights was provided on all occasions we observed. In all but one case we reviewed on the NCS, the record was updated to state that a letter of rights was offered.

70. The Police Interview – Rights of Suspects (PIRoS) form is only completed when a detainee is to be interviewed as a suspect. Where a detainee has been arrested as officially accused, or is not interviewed, it is unlikely that a PIRoS will be recorded. We witnessed PIRoS being carried out with detainees in a proper manner.

71. In 25 cases from our NCS sample, the detainee asked for a solicitor to be informed and this was met in almost all cases. In one case, there was no record to show if a solicitor had been contacted, another record had no contact page raised on the NCS, however there were notes in other sections to suggest that contact had been made. Notification to a reasonably named person was requested in 12 cases, and records show these were completed.

72. Three children aged between 13 and 14 and one older child aged 16, who was subject to a compulsory supervision order, were also included in our examination of the NCS. None were placed in a cell but were observed and supervised in an interview room. All had a parent or social worker present, which is good practice. However, only one of the four records indicated that the custody review inspector (CRI) had been made aware of a child in custody for management oversight purposes. We highlighted the need for increased management oversight of children in custody in our report on Glasgow custody centres whereby **Recommendation 3** of the report states:

"Police Scotland should ensure that custody decisions regarding children detained in custody are subject to robust management oversight and are recorded appropriately."

While this has relevance for Falkirk custody centre, we do not intend to make an additional recommendation in this regards.

73. In practice, only those who are arrested as not officially accused, or under suspicion, are the subject of scrutiny by the CRI – with reviews taking place at six, twelve and eighteen hours. These reviews require that investigation is diligent and expeditious. After an investigation is complete, a detainee's status may change to 'officially accused'. An officially accused person in custody is not monitored by the CRI and there appears to be limited scrutiny by sergeants to ensure that when a decision is made to release a detainee, liberation from custody is not unduly delayed.

74. This is a concern, and suggests a lack of oversight of criminal justice decisions relating to detainees with officially accused status, particularly relating to oversight of reviews and ensuring timely release.

75. The CRI had input to four records within our sample. One related to awareness of a child in custody, two related to six-hour extensions, and one where further extensions were made.

76. Our review found two cases were there was a delay in releasing the detainee after the decision to release was made. Both related to drink drivers where one was held for a further four hours and another for a further 16 hours. There was no rationale to explain the legal grounds to continue depriving liberty and there was no recording of a referral to a healthcare practitioner. We appreciate that it is likely that the detainees were held until they were sober under the terms of the Road Traffic Act 1988 s10(1) which can be used if there is a belief that a person will drive again whilst intoxicated. However, the records lacked any note to explain the decision.

77. Article 5 of the Human Rights Act relates to the right of liberty. Where a person's liberty is to be delayed after charge, there should be a note to explain the legal grounds for this as the grounds of arrest have lapsed. In situations such as this, that rationale should include what evidence exists to satisfy the belief they will again drive a motor vehicle whilst intoxicated. We noted a similar absence of notes in our inspection of Glasgow custody centres. Reference to this matter was also made in our report on the joint inspection of Ayrshire custody, within which **Recommendation 1** states:

"Police Scotland should review compliance with policy relating to the delay of release following a disposal decision being made and ensure that staff adhere to this."

While this has relevance for Falkirk custody centre, we do not intend to make an additional recommendation in this regards.

78. Overall, release decisions appeared appropriate and consistent with Lord Advocates Guidelines (LAGs). Detainees were released via the public counter or side door. Both routes are short and secure. As the custody centre is located in the centre of Falkirk, it provides easy access to public transport options. Detainees were assessed prior to release and consideration given to calling relatives, asking police officers to transport detainees home, or to use petty cash to pay for public transport if the detainee had no funds.

79. The centre gave due consideration to issues relevant to release such as the time of day, the clothing worn by the detainee, their age and ability to care for themselves, the distance to home, and availability of transport methods.

80. Detainee's are assessed prior to release and asked two pre-release risk assessment (PRRA) questions prior to leaving, regardless of their status. These relate to whether or not the individual has any thoughts of self-harm or suicide, or thoughts of harming anyone else. The PRRA was completed in all cases and all responses were negative.

81. When a detainee is transferred to GEOAmey to be escorted to court, custody staff must complete a person escort record (PER). This form is important in that it informs the escort provider of any identified health issues and any other identified risks that a detainee may have to ensure their ongoing care. We examined a sample of these and found them to have been completed to a good standard.

82. Of the 40 records we examined, 16 were held for court, 13 released on an undertaking, five were released for summoning report, five were released without charge and one was released on investigative liberation. These are typical ratios and are consistent with national trends.

Risk assessment and care plans

83. During the booking-in process, a risk assessment is carried out for all new arrivals to police custody. Detainees are asked a range of questions by custody staff based on a pre-determined vulnerability questionnaire. The purpose of the questionnaire is to identify past or present issues in relation to physical and mental health, substance use, self-harm, suicidal ideation or other vulnerabilities.

84. Effective risk assessment is vital to ensure that detainees can be managed and cared for appropriately. These questions are personal in nature, and we saw that staff were sensitive and respectful in their approach. The questionnaires were consistently completed well. We saw risk assessments and care plans being formulated though discussions between the CJPCSO and the team leader or sergeant. A vulnerability assessment was completed in almost all cases within our sample.

85. The initial risk assessment process allows custody staff to determine a bespoke care plan for detainees and involves determining whether the person presents high or low risk and applying a corresponding level to determine the appropriate frequency of wellbeing observations. This approach is based on an assessment of threat, risk and vulnerability. Responses to the vulnerability questionnaire and the subsequent care plan should be recorded on NCS. Based on the outcome of the risk assessment, detainees are subject to observations and rousing[5] in accordance with the following standardised scale:

- **Level 1 – general wellbeing observations**. For an initial period of six hours, all detainees are roused at least once every hour. Thereafter, hourly visits are still undertaken but detainees need not be roused for up to three hours. This level is suitable for detainees who are assessed as low risk.

- **Level 2 – intermittent observations**. Detainees are visited and roused at 15- or 30-minute intervals. This level is the minimum for detainees suspected of being under the influence of alcohol or drugs, whose level of consciousness causes concern or where there are other issues necessitating increased observation. This level can also be enhanced by the addition of CCTV observation of the detainee in their cell, with images appearing on a monitor in the staff and/or supervisor's office.

- **Level 3 – constant observations**. The detainee may be under constant observation via CCTV, a glass cell door or window, or a door hatch. Visits and rousing may take place at 15, 30 or 60-minute intervals.

- **Level 4 – close proximity observations**. Appropriate for those detainees at or posing the highest risk. This involves detainees being supervised by staff in the cell or via an open cell door.

[5] Rousing involves gaining a comprehensive verbal response from a detainee, even if it involves waking them while sleeping. If a detainee cannot be roused, they should be treated as a medical emergency.

86. Team Leaders and supervisors have other tactical options to mitigate risk. For example, a referral can be made to a healthcare provider, the detainee can be provided with anti-ligature clothing or can be placed on enhanced observations. Enhanced observations, means that the cell CCTV images are streamed live to a monitor in the custody office for staff to view occasionally as they carry out other tasks. It is a less intrusive and resource intensive option compared to the above noted Level 3 observations, although policy indicates that it should be accompanied by 15 or 30-minute observation cell visits.

87. Within our sample of records, the vulnerability risk assessment of 29 detainees were assessed as high risk and 11 as low risk.

88. Of the records marked as high risk, 15 were placed on level 1 observations without any other apparent risk mitigation in place. The number of instances where a detainee is deemed to be high risk but remains on standard observations with no mitigation in place (or recorded) remains an ongoing concern referenced in our previous reports. **Recommendation 2** of our report on the joint inspection of custody in Ayrshire states:

"Police Scotland should ensure that custody staff have a clear understanding of what response is required for each of the defined observation levels and that these are applied consistently."

While this has relevance for Falkirk custody centre, we do not intend to make an additional recommendation in this regard.

89. Unlike the findings outlined in some of our previous inspection reports, we found no references to so called '2.5' observation levels, a term used to denote enhanced observations. A custody sergeant informed us that guidance had been circulated within the preceding six months stating this categorisation of observation was invalid and staff should instead refer to the designated categorisation as detailed in the procedural documentation. They went on to accurately describe the respective observation categories in accordance with CJSD guidelines. It is very positive to see this change in practice.

90. There were eight records where a detainee had been placed on a high level of observations which, during their time in custody, was reduced in line with dynamic risk assessment. One record detailed a structured de-escalation of observation levels from level 4 through to level 1, over the period of detention and with appropriate rationales recorded on the NCS. We consider this to be good practice.

91. Observation visits and the provision of food, drinks, blankets, pillows and books when requested are generally carried out by CJPCSOs. Such activity should be recorded on the NCS. At Falkirk, as at other custody centres, staff make a note of each transaction and then update information onto the NCS when they return to the office, which may take some time depending on any interruptions. We consider this delay in recording can lead to omissions of information, inaccuracy in the detail, and can raise questions about the integrity of recorded information.

92. In our review of NCS records, we checked the time difference between the actual cell visit time logged on the NCS and the time stamp relating to when it was recorded on the NCS. Of the 40 records examined, 28 had cell visits recorded. The longest time difference between the observation visit and recording on the system was 28 minutes, though most were under ten minutes.

93. These times are considerably better than those found on our inspection of Glasgow custody centres, where the longest time found was 86 minutes, with several others exceeding 20 minutes. A correlation can be made between the size of the centres and the higher level of throughput at Glasgow. Nonetheless, we consider that this practice introduces unnecessary risk.

94. This matter has been the subject of previous HMICS recommendations where the ability to make contemporaneous records of interactions with detainees using an electronic tablet was considered best practice. **Recommendation 1** from our inspection report on custody services in Northeast Scotland states that:

"Police Scotland should replace the existing paper-based recording system at Kittybrewster with an effective and reliable electronic system that can be updated in real time from the location that cell checks are being undertaken."

Recommendation 3 from our joint custody inspection report on Lanarkshire stated:

"Police Scotland should ensure that processes for recording cell checks are carried out consistently and recorded on the national custody system timeously."

We understand that tablets previously provided for this purpose have been temporarily removed from all centres pending a review. However, we consider these recommendations to continue to have relevance for practice across all custody centres.

95. From the sample examined, it was recorded that 18% of detainees were intoxicated on arrival, 5% declared they were alcoholics and 15% were drug dependent. Forty three per cent disclosed a mental health condition and 35% reported they had previously self-harmed or had attempted suicide. A further 35% were on prescribed medication and 23% stated they had difficulty with reading and writing. Thirty five per cent had consumed alcohol and 16% had used drugs prior to arrest. All had some form of criminal or police information record.

96. Statistics relating to mental health were similar to those found in our recent inspections in the west of Scotland, but there were fewer recorded instances of addiction issues. Overall, there is a correlation between health, vulnerability and offending which is reasonably consistent across the country. It highlights the high level of risk, addiction, mental health, and medical health challenges presented to police custody daily.

97. Eleven detainees from our sample were strip searched. Two records had no search page. One had no comment in the record that suggested a standard search occurred. Another stated that a strip search had been authorised by a constable rather than a sergeant as required by policy. The remainder of strip searches had a rationale which, while often very brief, indicated a proportionate decision. We have previously raised concerns regarding the recording of strip searches. **Recommendation 3** from our report on the joint inspection of Tayside custody centre states:

"Police Scotland should ensure that the recording of strip searches at Dundee custody centre provides an accurate reflection of practice."

While this has relevance for Falkirk custody centre, we do not intend to make an additional recommendation in this regard.

98. When staff are relieved at the end of duty by the following shift, it is considered appropriate to conduct a handover meeting to discuss the risks and ongoing issues relative to the custody centre and detainees. This discussion should be recorded onto the corresponding NCS record. Sergeants must review the criminal justice decisions and satisfy themselves that the grounds for a given decision remain. Supervisors and staff must familiarise themselves with the risk and vulnerability assessment of detainees in custody, their presentation, and any matters that impact on their safe care. These handover discussions should be documented on the NCS.

99. We found that the recording of a handover appeared in 17 records. There was no handover recorded in 23 records, although where a detainee arrives and leaves during the duty of one shift, no handover would be expected. There were however, six records without a handover recorded, where we consider one should have been present.

Area for improvement 2

Falkirk custody centre should ensure that handovers are undertaken and recorded in line with existing guidance and standards.

Detainee care

100. We interviewed 11 detainees at the custody centre. All were complimentary about the custody staff and the care they provided. Two detainees offered particular praise for the additional time staff had spent to speak to them and provide support. The feedback was consistently good.

101. Twenty four records indicated that meals were provided. Ten detainees were not lodged and there was no record of food being provided. Most were released quickly but in two of these instances, the detainee was held for more than five hours, spanning a typical mealtime and should have been provided with food. However, this is most likely to be a recording issue. Just 12 records indicated that a drink was provided. It is noted however that the custody centre cells have in-cell taps where detainees can obtain water which is suitable to drink when they wish and, during our inspection, we saw detainees with cups provided for this purpose.

102. No records referred to detainees being offered a wash, however all cells have in-cell sinks which allow detainees to wash themselves when they wish, which may explain the lack of distinct reference to this in records. Showers were recorded as being offered on a Sunday but not mid-week which seemed unusual.

103. The NCS has a page to record the movement of detainees to the medical room, interview rooms, and for fingerprinting or intoximeter processes. It provides a time stamp indicating when a detainee leaves their cell and the point at which they return. We noted a haphazard approach to recording of this, with only occasional entries relating to movements to interview. There were three records where a detainee was marked to interview but not returned on the system.

104. Despite some recording on NCS being detailed and thorough, we saw consistent recording errors with movements, meals, provision of legal rights, handovers, consultations with healthcare professionals, and care plan rationale. A lack of accuracy in record keeping has been a recurring theme within previous inspection reports. **Recommendation 3** of the report relating to the joint custody inspection of Argyll and West Dunbartonshire states:

"Police Scotland should introduce an effective quality assurance and audit process to ensure that expected custody standards are being met."

While we recognise that the issue of quality assurance and audit is being addressed by CJSD through the introduction of a dedicated post, it is evident that while some improvements have been identified, we have not yet seen more widespread benefits.

105. Where considered appropriate, detainees should be asked if they would like to be referred to a third sector agency to provide them with support on issues such as addiction and mental health. The availability of support services differs from area to area, however, NCS has a compulsory field that staff must update to indicate if the offer was accepted, declined or was not appropriate.

106. Within our sample of records, the offer of a referral was declined in 30 instances, and was considered not applicable in ten instances. However, in two of those, the record indicated clear addiction issues where a referral would appear to have been appropriate.

107. A custody sergeant described a frequently utilised arrest referral service called 'Change, Grow, Live'. Staff from this service were at the centre during our inspection, as per their weekly visit schedule. Some custody staff expressed frustration that workers attend on a Monday morning after detainees are transferred to court, rather than on a Sunday which is considered as the optimum opportunity. Referrals can be made out with their stated schedule via submission of a request form.

108. Custody staff were also able to refer detainees to 'Transform Forth Valley', a Drug and Alcohol support service, and the male mental health support services delivered by Barnardos and 'Andy's Man Club'. We saw relevant leaflets and literature readily available throughout the centre. A sergeant had been allocated as the lead for referrals and each team had a champion, tasked with raising awareness and encouraging colleagues to promote available services and make referrals.

109. The dispensing of medication at the centre was recorded consistently on the NCS although only one staff member was assigned to each entry. Accordingly, it is not possible to ascertain if two members of staff carried out medication dispensing in line with policy. The issue of training and compliance was addressed in our joint custody inspection report relating to Dumfries and Galloway. **Recommendation 13** of that report states:

"Police Scotland should ensure that custody staff are provided with appropriate training in relation to the administration of medication and that this is provided and refreshed in accordance with national guidance and best practice."

While this has relevance for Falkirk custody centre, we do not intend to make an additional recommendation in this regard.

Staff training

110. All custody staff are required to complete standard custody training, which is comprised of two mandatory courses, a custody officer induction course covering custody care and welfare lasting three days, and two days training on the NCS. They are also trained in first aid, officer safety, fire safety, and data protection. Some staff are trained in CHS and PNC, which is hosted at the police training centre at East Kilbride.

111. Some supervisors had received two days online supervisor training, which replaced the former two week supervisors course delivered at the Scottish Police College. There were concerns raised by some staff that there is no specific team leader training, which is an issue that was highlighted in our inspection of custody centres in Greater Glasgow. Custody staff also highlighted that the current officer safety training course had limited relevance for custody staff as it focussed on frontline policing. However, custody staff will receive a more in depth three day first aid course.

112. We have outlined the need for additional training for custody staff through recommendations made in our previous custody reports. We have highlighted that training custody staff in issues including substance use, mental health, trauma informed care, and undertaking detainee observations, would enhance their ability to meet the needs of vulnerable individuals more effectively.

Healthcare

Governance

113. Falkirk custody centre sits within the NHS Forth Valley board area. Healthcare is delivered by the Southeast Scotland Police Custody Healthcare and Forensic Examination Service, which is hosted and managed by NHS Lothian. The service is nurse led with leadership provided by a Clinical Nurse Manager (CNM).

114. The 'southeast cluster' covers other NHS boards, which means healthcare is provided peripatetically and is therefore not based in a single custody centre. Healthcare staff operate 24/7, 365 days a year with two Forensic Physicians providing 'on-call' cover for both day and night shifts. The nursing team featured a combination of Adult Health Nurses (RGNs) and Registered Mental Health Nurses (RMNs) who were trained to support the physical and mental health as well as drug and alcohol support requirements meaning detainees would receive care responsive to their individual needs. This is considered good practice.

115. Twice daily staff huddles took place which enabled staff to effectively coordinate care and hand over any outstanding patient or service issues to the staff coming on duty.

116. Healthcare was well managed, with NHS Lothian's Royal Edinburgh Hospital and Associated Services (REAS) providing clear management structure, monitoring and oversight through its clinical and care governance processes. Healthcare staff had regular meetings and enjoyed good working relationships with Police Scotland and NHS Forth Valley enabling coordination contingency planning in advance of any changes that could occur operationally, such as planned opening or closing of custody centres.

117. An induction programme for all new healthcare staff was available. Training records showed good compliance with mandatory and role specific training, which included equality and human rights, the Istanbul Protocol and trauma informed practice.

118. The service had a regular programme of audits in place. A Forensic Medical Examiner (FME) scorecard and a Senior Charge Nurse (SCN) assurance checklist had been introduced to capture data which was used by the Clinical Nurse Manager (CNM) to generate reports for discussion at joint meetings.

119. Staff received supervision from the SCN every eight weeks, which was a combination of managerial and clinical supervision. We were informed that all healthcare staff had a current personal development plan and a regular appraisal system in place.

120. The current national electronic system for recording healthcare data across all custody centres in Scotland, Adastra,[6] did not provide sufficient functionality to enable data pertaining to clinical interactions to be appropriately recorded, monitored and reported. REAS therefore developed their own supplementary local processes to collate this data. This is considered good practice. Healthcare recommendations were emailed to the generic custody email and then copied onto NCS. Additionally, health and police custody staff were able to provide verbal updates on the patients' healthcare needs.

121. There was information displayed in the custody centre about how detainees could make a complaint or give feedback. At the time of inspection, there had been no complaints received in the past 12 months. The DATIX[7] risk management information system was used appropriately to report incidents. These were discussed at clinical governance meetings.

122. The medical treatment room and equipment was visibly clean and in a good state of repair, with a hand wash basin and personal protective equipment available for use. Flooring, work surfaces, and ceilings were all intact ensuring effective cleaning could be carried out. The police appointed cleaner had access to clean the treatment room floors. Healthcare staff undertake cleaning of the surfaces and medical equipment after each use of the treatment rooms. An appropriate chlorine-based cleaning product was available in line with current guidance. Cleaning of the cells and custody areas in all centres, including the management of blood or body fluid spillages, was completed by an external company.

[6] Adastra is an IT solution for use in police custody centres used by NHS staff and commissioned services. It is used as a clinical health recording system to support clinical care delivery for patients in police custody.
[7] Datix system is an online system for all healthcare staff to report any incidents and risks.

123. Sharps bins, which are used to dispose of used sharp items, were correctly labelled with temporary closures in place. Clinical waste was disposed of in line with guidance. Inspectors saw that clinical waste was stored securely in a locked area.

124. No linen was used by healthcare staff. Linen used in the custody area was managed by custody staff and was laundered by an external company. Used lined was stored securely while awaiting collection.

125. We were told that there was no infection prevention control (IPC) lead for the Falkirk custody centre. However, staff could obtain IPC advice from NHS Lothian's IPC Team. We observed that the National Infection Prevention and Control Manual (NIPCM) was available on the staff shared drive. Training records showed that all healthcare staff had completed IPC training.

126. Systems and processes were in place to manage medical emergencies. Emergency equipment which included oxygen, the suction machine and automated external defibrillators, were available with regular checks being completed. All healthcare professionals had access to basic life support training.

Access to healthcare

127. When people were brought into custody their healthcare needs were identified through a vulnerability questionnaire completed by custody staff. The information given by the detainee when completing the vulnerability questionnaire may result in a referral being made to healthcare staff.

128. There is no nationally agreed waiting time standard for healthcare assessment of individuals detained in police custody centres across Scotland. However, the service operated a model where all Police Scotland referrals for the southeast cluster were received by the REAS central hub. Referrals for Falkirk police custody were sent electronically to the nurse covering Falkirk custody centre to be triaged. This allowed REAS to monitor the time from referral to triage and first assessment. This is considered good practice. Waiting times would vary depending on the number of detainees in custody, the information gathered from the triage assessment and the location of the nurse on duty.

129. Detainees could also request to see healthcare staff at any point. Information regarding healthcare was included in the booklet ‘your rights when you are at the police station’. This was in easy read format and was routinely given to detainees. This is considered good practice. Healthcare and police custody staff could also access interpretation services to support patients with the vulnerability assessment and ongoing healthcare assessments. Language identification posters were visible in the charge bar area of the custody centre.

130. Custody staff were complimentary about the healthcare service provided at Falkirk. Attendance times and medical feedback provided to custody staff was considered clear and helpful. Custody staff described good partnership working arrangements.

131. The Criminal Justice Service Division (CJSD), in collaboration with healthcare partners, had produced guidance and clarity for custody staff on their role and responsibilities to maintain patient confidentiality for detainees when undergoing intervention and treatment by the healthcare team. Inspectors were told that this was being followed and monitored, with clinical examinations generally carried out in the treatment room. Inspectors were told that the door to the treatment room would be closed, unless custody staff had highlighted this as a safety risk.

132. NHS staff were aware of the process for identification and documentation of injuries allegedly sustained as a result of force. Where possible, any detainee request for specific healthcare staff to carry out health assessments would be facilitated.

133. All cells at the custody centre were wheelchair accessible. Inspectors were told if detainees had complex physical, social or care needs, a fitness to remain in custody assessment would be completed by the registered nurse, followed by joint discussion between custody and healthcare staff. This is considered good practice.

Medicines management

134. NHS Lothian have a pharmacist with responsibility for overseeing the governance of medicine management in the custody centres in the southeast cluster, which includes Falkirk. The service had standard operating procedures (SOP) to support staff with the safe supply, storage, dispensing and safe destruction of medicines. A process was also in place to order medications including controlled drugs.

135. Healthcare staff informed us NHS Lothian's Controlled Drugs Governance Team would, when required, visit the custody centre to safely destroy out of date, or no longer required, controlled drugs. We observed that controlled drug registers were well completed, and the current controlled drug license was in the process of being renewed. A recent review by NHS Lothian's Controlled Drugs Governance Team did not raise any concerns. The service had processes to ensure effective stock rotation and checking of expiry dates. During this inspection, drugs that were checked were found to be in date.

136. Various methods were used to ensure robust medication reconciliation, including checking electronic records and speaking with the patient. This ensured that patients received their usual medication whilst detained, including any Opiate Substitution Therapy (OST). Most nurses were non-medical prescribers and prescribed all medications, prescriptions were recorded on Adastra. This included prescriptions for controlled drugs.

137. We noted that the current process for prescribing controlled drugs did not include a wet signature of the prescriber. As a result of this, an urgent meeting was called with the Associate Director of Pharmacy with responsibility for police custody centres to provide immediate assurance that all medicines prescribed at Falkirk custody centre was carried out by appropriately qualified clinicians. NHS Lothian staff informed us that while the Adastra system had unique log-ins for all users, and all system activity was recorded and auditable, both prescribers and non-prescribers could prescribe.

138. During this meeting, we were informed of a situation where a non-prescriber had accessed the system and prescribed medicines for a detainee's compliance aid. This is a concern.

139. We have requested that NHS Lothian provide written assurance that the current process for prescribing controlled drugs via the Adastra system is both safe and compliant with the relevant regulations.

Recommendation 1

NHS Lothian must review the prescribing processes in Falkirk police custody centre and strengthen the governance of medication prescribing.

140. Healthcare staff dispensed medication into multi-compartment compliance aids to enable custody staff to administer medication, this does not include OST which was dispensed by a nurse. The compliance aids were held by custody staff who received email instructions from healthcare staff to support safe medicine administration. Although healthcare staff were able to describe the process for using compliance aids, the service did not have a current SOP or training package to support the use of compliance aids.

Recommendation 2

NHS Lothian should ensure all staff receive appropriate training and guidance to support the use of compliance aids.

Substance use

141. The vulnerability questionnaire used by custody staff included questions regarding the use of alcohol or substances and whether detainees had substance dependency. Nursing staff assessed detainees who appeared to be under the influence or withdrawing from alcohol or substances. They had access to the appropriate tools for monitoring withdrawals, carrying out physical observations and prescribing detoxification medication where required.

142. The Scottish Government's MAT standards came into force in April 2022. These are evidence-based standards to enable the consistent delivery of safe, accessible, high-quality drug treatment across Scotland. During the inspection we saw that the implementation of the MAT standards was being progressed by REAS within the custody settings.

143. Processes were in place for confirming, collecting and administering community prescriptions for patients within custody who lived locally and were prescribed OST. As there was no stock of OST medicines within the centre, those patients who did not access local services for their OST, their prescription could not be collected and their treatment stopped; they would be offered a detox. They would then need to recommence their OST once liberated. This did not support the continuation of people on their treatment or align with the principles of the MAT standards.

Recommendation 3

NHS Lothian and REAS should continue to review their pathways for people who use the Substance Use Service to ensure it aligns to the principles of the MAT standards.

144. Although the majority of nursing staff were nurse prescribers, facilities were in place if detox medication was required. These Patient Group Directions (PGDs), are written instructions in the absence of a prescription, which enable registered health professionals to administer medicines to pre-defined recipients.

145. While there was a process in place for nicotine replacement therapy to be made available to detainees who smoked, feedback we obtained from detainees indicated that this was not consistently offered to those at risk of nicotine withdrawal.

Recommendation 4

NHS Lothian should ensure that all detainees at risk of nicotine withdrawal are offered nicotine replacement therapy.

146. Naloxone was available within the centre which was administered by nursing staff. We were told that two police officers were trained to carry naloxone. We did not see any information displayed about naloxone within the custody centre. A choice of nasal or injectable naloxone was available for issue to patients on release. However, this was only for those patients who had been identified as having a history of substance use. This is despite the NHS Lothian induction pack for new CFNs stating that 'take home naloxone' should be offered to all detainees.

Recommendation 5

NHS Lothian should ensure that take home naloxone is offered to all detainees in accordance with the induction policy.

147. We saw that there was information on harm reduction and resources available to patients when they met with healthcare staff. At the time of our inspection, BBV testing was not available at the custody centre. We were told that a pilot was being undertaken in another custody centre covered by REAS.

Recommendation 6

NHS Lothian should urgently review the options for the delivery of BBV testing so that it is available in Falkirk custody centre.

Mental health

148. Custody staff at the centre can request nursing staff to undertake fitness for court, release, and detention assessments. There was clear guidance for healthcare staff on completion of these assessments. Inspectors viewed a standardised assessment tool used to record assessments, which included the patient's history, details of examination, assessment and recommendations. Where concerns for a patient's wellbeing was identified, risk management plans were shared with custody staff in line with recommendations made by healthcare staff. This included enhanced monitoring or observation levels where there was a concern for a patient's wellbeing.

149. Where a full mental health assessment was required e.g. for a detainees' fitness for court, referral was made to the court liaison service. For patients requiring transfer to hospital following an initial mental health assessment, clear pathways were in place. Fitness to release assessments were comprehensive and completed using validated mental health and suicide risk assessments available on the Adastra system.

150. Detainees with learning disabilities could be identified from the vulnerability questionnaire and through screening the vulnerable persons database. Systems were in place to involve an appropriate adult service if required.

151. Custody data showed that Falkirk custody centre was not used in 2024 as a place of safety under section 297 and 298 of the Mental Health (Care and Treatment) (Scotland) Act 2003. This was positive and indicated that the pathways in place were followed to avoid a patient being brought into custody when a mental health assessment was required.

152. Training opportunities were in place for all nursing staff, which covered mental health care to enhance their skills and knowledge in a forensic setting. This is considered good practice.

Pre-release pathways and referrals

153. As previously noted, when a detainee is moved from a custody centre to another area, for example when going to court, a person escort record (PER) form is completed. This form contains information regarding the detainees' medical conditions and medications and is taken from NCS.

154. There was evidence of signposting detainees to community support services, and custody staff were knowledgeable about the support available in the community. A range of leaflets were available for mental health, substance use, health and wellbeing, harm reduction, peer support and family support available in the community.

155. Healthcare staff had satisfactory processes in place to communicate with community pharmacies, community mental health and substance use services where required for continuity of care.

Detainee transfers

156. The escort provider, GEOAmey, collect detainees each weekday morning to escort them to the appropriate sheriff court. From Falkirk custody centre, they are typically transferred to Falkirk, Stirling and Alloa sheriff courts. Staff advise that collection is usually prompt and early in the morning. Custody staff stated that if a detainee requires an individual transfer, or is on constant observations, they can remain in the police custody centre until afternoon. This is a trend we have seen across many custody centres and can be attributed to operational pressures experienced by GEOAmey and available court cells.

157. We spoke to a detainee who had been arrested in London on a Wednesday evening, to be presented at Inverness Sheriff court. They were collected on Saturday by GEOAmey and on Monday were still at Falkirk awaiting onward transfer. They did appear at court later than day having spent almost five days in police custody. We have previously reported that detainees arrested in England and brought to Scotland, often spend more days in custody than is reasonable or lawful. An arrested person should be presented to court on the next lawful day. These situations appear to be as a result of challenges relating to the ability of GEOAmey to consistently and effectively meet contractual requirements.

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